A Man Develops Panic Disorder After a Car Accident:

Response to Supportive Psychotherapy

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We will describe psychotherapy with a man who developed panic disorder after a motor vehicle accident. Early intervention, selection of therapeutic approach, important turning points in the therapy, the decision-making process of combining psychotherapy with medication, and successful psychiatric collaboration with the primary care physician are discussed.

CASE PRESENTATION: Psychiatric History and Diagnosis

Mr. J is a 50-year-old married man who had no previous history of psychiatric disorders, except for three visits with a psychologist following the loss of a grandchild to sudden infant death syndrome (SIDS) when the patient was 45 years old. The patient also had no medical hospitalizations, no chronic medical problems, and was a successful businessman who owned a corporation. He was born to an intact nuclear family, the second born and only male of a sibship of two. At the time he was initially seen, his chief complaint was, "I had a car accident," referring to an incident that had occurred five weeks prior to evaluation.

Mr. J stated the motor vehicle accident occurred as he was returning home from lunch with a friend. As he traveled through an intersection, another vehicle pulled out in front of him and did not yield despite Mr. J's right of way. His vehicle was struck in the right front quarter, and he stated, "No one was hurt." The driver of the other vehicle was an elderly man, and his wife was a passenger. Police were called, and Mr. J was encouraged to undergo medical assessment at an emergency department following the accident. He underwent a cervical spine X-ray and general medical examination, with the only abnormality being elevated blood pressure.

He had no prior history of hypertension, and he expressed concern and surprise to the emergency physician. His systolic blood pressures were in the 180s and diastolic blood pressures in the 120s, and he was started on amlodipine (calcium channel blocker) and discharged home with instructions to follow up with his primary care physician within two days.

Over the next four-week period his family practice doctor saw him several times, and a second antihypertensive (metoprolol, a beta-blocker) was added. He was taking metoprolol and amlodipine at the time of psychiatric assessment, still without well-controlled blood pressure. Mr. J specifically mentioned that at his

most recent visit with the primary care physician, the doctor suggested addition of a third antihypertensive, which caused the patient increased anxiety and feelings of being "out of control." He was referred for psychiatric consultation at that point.

When initially seen by the psychiatrist, Mr. J. complained of debilitating anxiety, inability to work, and a feeling of hopelessness that he would regain previous functioning level. He described the anxiety as episodic, and fluctuating in intensity. The predominant symptoms included depersonalization, palpitations, chest pressure, shortness of breath, and tremulousness. The anxiety reportedly occurred several times daily, and lasted for 15- to 20-minute periods. He avoided driving due to his fear of experiencing an anxiety attack rather than fear of another motor vehicle accident.

KEY POINT: Consultation with the Primary Care Provider

Prior to making the diagnosis of panic disorder secondary to the motor vehicle accident, especially in view of the presence of a new abnormal physical examination finding (hypertension), medical conditions that could account for the panic attacks and depressive symptoms (e.g., thyroid disorders, metabolic imbalances, vitamin deficiencies) were considered and ruled out. Medication side effects were reviewed to determine if some symptoms were related to antihypertensives or any other prescribed or over-the-counter medications. No physical cause for the panic and depressive symptoms were found.

PSYCHIATRIC DIAGNOSIS: Panic Disorder with Agoraphobia

Prior to his car accident, Mr. J did not have anxiety or hypertension and he had never missed a day of work. Now, he had not been able to work in over four weeks and also reported depressed mood, initial and middle insomnia, and decreased energy level.

TABLE 1. Diagnostic Criteria for Panic Disorder with Agoraphobia[1]

A. Both (1) and (2):

1. Recurrent unexpected Panic Attacks

- palpitations, pounding heart, or accelerated heart rate
- sensations of shortness of breath or smothering
- trembling or shaking
- sweating
- feeling of choking
- chest pain or discomfort
- nausea or abdominal distress
- fear of dying
- feeling dizzy, unsteady, lightheaded, or faint
- derealization or depersonalization
- feeling of losing control or going crazy
- parasthesias
- chills or hot flashes

2. At least one of the attacks has been followed by 1 month (or more) of one (or more) of the following:

- persistent concern about having additional attacks
- worry about the implications of the attack or its consequences (e.g., losing control, having a heart attack, "going crazy")
- a significant change in behavior related to the attacks

B. Presence of agoraphobia

C. The panic attacks are not due to the direct physiological effects of a substance or general medical condition

D. The panic attacks are not better accounted for by another mental disorder

Adapted from Diagnostic and Statistical Manual, Fourth edition, Text revision. American Psychiatric Association, 2000.

Although Mr. J reported several depressive symptoms, his complaints of anxiety were more prominent, disruptive, and disabling at the time of presentation. The subjective complaints described panic attacks, and the frequency, severity, and other qualitative components supported a diagnosis of panic disorder with agoraphobia. See Table 1 for diagnostic criteria for panic disorder with agoraphobia.

KEY POINT: Patient Participation in the Decision-Making Process Regarding Medication—A First Supportive Step

Due to the severity of his symptoms and significantly decreased ability to function, various options for pharmacological interventions were discussed while developing the therapeutic alliance needed for supportive psychotherapy. Mr. J was already alarmed at the idea of needing additional antihypertensive medication. He related his discomfort with the two antihypertensives already prescribed. He also was wary of taking medication at all, which he had never needed to do before, and clearly stated he was uninterested in taking psychotropic medication as a long-term treatment option.

However, because of the degree of functional impairment he was suffering, he agreed with the need to control symptoms acutely so that he could restart moderate daily exercise, work activities, interaction with family members, and regain his ability to sleep and eat normally. Various options were discussed, including antidepressant medication, psychotherapy without pharmacotherapy, or a short course of anxiolytics along with supportive psychotherapy.

TABLE 2: Patient selection for short-term supportive psychotherapy

- Previously or usually strong coping skills
- An acute crisis requiring temporary intervention
- A sense of internal conflict
- The ability to obtain symptom relief through understanding
- The ability to contain or tolerate affect
- Good social support or temporarily disrupted social support
- Good object relations
- Good impulse control
- Good reality testing
- Intact cognitive abilities
- Trust of the therapist
- Motivation for treatment
- Mature defenses
- Mature coping mechanisms
- Psychological mindedness
- A tendency to internalize causes of failure
- The ability to identify and speak of emotions

Adapted from Novalis PN, Rojcewicz SJ, Peele R. *Clinical Manual of Supportive Psychotherapy.* Washington, DC: American Psychiatric Press, Inc., 2003.

In the case of panic disorder, appropriate pharmacological interventions can include selective serotonin reuptake inhibitors, tricyclic antidepressants, benzodiazepines, and monoamine oxidase inhibitors.[2]

Benzodiazepines may be used for acute treatment, but should not be used long term due to habituation and the potential for abuse.[3] Mr. J had no history of substance abuse and did not want to take medication for a long period of time. He was prescribed alprazolam 0.5mg tablets to be taken three times daily for 4 to 8 weeks. Had his symptoms not improved, a change to another medication would have been discussed.

INITIATION OF SHORT-TERM SUPPORTIVE PSYCHOTHERAPY

Mr. J. was a good candidate for short-term supportive psychotherapy. He had already developed strong coping skills, as evidenced by his recovery from the loss of his grandchild (ability to obtain symptom relief through understanding), his achievements as a businessperson (intact cognitive abilities), his collection of close personal friends (good social support), and his use of humor and altruism (use of mature defenses). Table 2 describes the criteria for patient selection for short-term supportive psychotherapy.

First stage of supportive psychotherapy. During the first three sessions, Mr. J provided more details about his previous level of functioning and recounted in great detail his motor vehicle accident (MVA). He explained that he was married, a successful businessman, and worked approximately 60 hours per week. He employed 10 people and was responsible for all marketing and accounting procedures in the business. Since the MVA five weeks prior, he found himself unable to work; each time he attempted to drive to his office, he had to return home because of a panic attack. In the two weeks prior to initiating psychotherapy, the anxiety worsened and he stopped driving, exercising, and eating regularly.

Mr. J was forthcoming regarding the details of the MVA and processed the traumatic event by recounting that day's events to the psychiatrist in some detail, which was encouraged. He described the errands he had performed that morning and that he had looked forward to lunch with a friend. After leaving the restaurant that Saturday afternoon, he traveled approximately one mile and was proceeding through an intersection when another vehicle failed to yield and ultimately hit his vehicle in the front right quarter.

He remembered such details as the comments made by passersby and by emergency personnel. He recalled calling his best friend and then his wife. The other car was occupied by an elderly couple that did not approach Mr. J or converse with him. The patient described the medical examination in the emergency department and hearing the news that he had high blood pressure for the first time.

He recounted the details of his experience several times during initial therapy sessions, at times repeating the same things over and over. Initially, he focused only on the mechanics of the accident, the damage to the vehicle, and the environmental conditions. The psychiatrist actively encouraged this reliving of the traumatic experience and was proactive in ensuring the patient gradually attached emotion and affect to the descriptive account. By the third session, he began attaching emotions to the events voluntarily and without prompting, expanding on his anger, disappointment, frustration, and fear since the accident. Mr. J also shared a dream he had the week following the MVA in which he watched helplessly as a currently living granddaughter was abused physically and sexually and ultimately left for dead. In the dream his attempts to intervene were fruitless, and in fact he could not speak or react in the dream. He interpreted this on his own as an expression of the helplessness he felt at the time of the accident and feeling of "being out of control." He also identified that at the moment just preceding impact of the other vehicle, he faced one of his worst fears: that he would lose his life and not be a part of his grandchildren's lives. He also had for several years felt the granddaughter in the dream needed more from him than his other grandchildren because of her specific family dynamics.

Mr. J was especially angry that the other driver had not apologized nor attempted any contact, such as a note of concern. In contrast, Mr. J received a telephone call from the other driver's insurance agent and was told that he should accept a settlement of $1,000.00 to cover medical costs and "move on and get back to work." See Tables 3 and 4 for recommendations and therapeutic strategies for panic/anxiety disorders.

KEY POINT: The Patient in Crisis

The structured "trusting, confiding, emotional" relationship of supportive psychotherapy boosts the patient's morale, especially when it is combined with a treatment setting that has an aura of safety and sanctuary.[4] Typically the therapist actively provides some relief in the first sessions and work on developing a future plan that provides hope. Although previously healthy people in crisis could tolerate the additional stress of confrontational interpretations and therapeutic style, this is not necessary and often not helpful in a time of crisis. Supportive therapy may be more appropriate because it "buys time" and enables the patient to readapt using already developed personal resources.[4] Such patients are unlikely to become inappropriately dependent on the therapist from a brief period of support. Although the therapist provides the patient with some advance structure, the patient is a collaborator and not passive.[4] A similar patient might ask the psychiatrist to authorize time away from work, and an appropriate collaborative intervention in this circumstance would be to weigh the alternatives in the room with the patient by asking,[4] "Let's consider what effect your time off work will have on the business, and explore options for your return. What are your thoughts?"

KEY POINT: Resurfacing of Grief Issues in Supportive Psychotherapy

In later sessions, Mr. J. spoke more about the need for treatment of new onset hypertension than about the details of the accident, and admitted that he skipped some of the antihypertensive medication doses. He revealed that his mother had suffered from multiple medical problems, including hypertension, in the years before her death, and had been prescribed the same medication.

The psychiatrist recalled that, at initial evaluation, when asked about developmental years, the patient's first response was, "My mother abandoned me." The patient did not expand on this remark, because his focus was on the debilitating panic attacks, and the psychiatrist did not question him further at that point. Several weeks later, though, with panic symptoms less intrusive, the patient was asked about his relationship with his mother. He reported that his mother had died two years ago. The patient had spent much time prior to his mother's death in a caretaking role. He traveled to a nearby city nearly daily for many months to provide support to his mother, who suffered from multiple medical problems, including Alzheimer's disease and hypertension.

KEY POINT: Dynamic Principles in Psychotherapy

In pursuing medical and psychiatric treatment following the accident, Mr. J was put in the position of accepting a dependent role in his relationship with both the internist and psychiatrist. Although in supportive psychotherapy the psychiatrist does not typically make interpretations to the patient, the therapist is aware of the likely dynamics. At this point in the psychotherapy a decision is made whether to meet some of the dependency needs in loco parentis, or to be a peer collaborator.

Mr. J recalled that he had said he felt "abandoned" by his mother. He stated that at the age of five years, his mother left him at the home of his maternal grandmother, because his parents were experiencing marital difficulties and temporarily separated. Neither of his biological parents felt capable of raising a child alone, and the patient lived with his grandmother for the remainder of his developmental years. His mother had been a transient figure in his life ever since, and when Mr. J heard of his mother's failing health, he made attempts to reconnect through a caretaking role. He felt he did not accomplish this task, largely because of his mother's memory difficulties and cognitive decline.

The patient felt saddened and angry at the other driver and passenger, who did not inquire about his condition. These people were elderly and may have reminded him of his parents, who did not care about him. The simultaneous initiation of 1) his mother's previous medication regimen and 2) the elderly couple in the motor vehicle accident denying Mr. J compassion and acknowledgment of his emotional and physical pain likely caused the resurfacing of unresolved issues in his ambivalent relationship with his mother, making him more vulnerable to psychiatric pathology, such as new onset panic disorder. The patient had unmet dependency needs in the past and, therefore, the

TABLE 3: Recommendations for treatment of panic/anxiety

- **Medical evaluation**
- **Reduction of caffeine and other stimulants**
- **Medication**
- **Behavior therapy techniques**
- **Family sessions**
- **Treatment of associated symptoms**
- **Availability of "booster" sessions**

Adapted from Novalis PN, Rojcewicz SJ, Peele R. *Clinical Manual of Supportive Psychotherapy.* Washington, DC: American Psychiatric Press, Inc., 2003.

TABLE 4: Therapeutic strategies for anxiety symptoms

- **Show willingness to alleviate symptoms**
- **Make empathetic statements that address the patient's anxiety**
- **Provide a diagnosis or explanation**
- **Communicate realistic optimism**
- **Explore possible medications/specific techniques that can be used to alleviate symptoms**
- **Pay attention to your own anxiety but try not to show it**

Adapted from Novalis PN, Rojcewicz SJ, Peele R. *Clinical Manual of Supportive Psychotherapy.* Washington, DC: American Psychiatric Press, Inc., 2003.

potential for hostility when these needs were not acknowledged now.

INTEGRATING PAST PATTERNS AND CURRENT FUNCTIONING

Mr. J had some recurring themes in his relationships. He tended to be submissive and passive in personal relationships but powerful and proactive in the business world. He also had self-esteem problems and poor self confidence in close personal relationships, which caused him to make poor decisions and attempt to continually please others. He described his relationships with his wife and only child (an adult son) as "strained." They both had substance use problems, and he preferred to keep "distance" from them as much as possible. A consequence of this was his commitment to and immersion in his career, and thus the 60-hour work weeks allowed him to both attain success and temporarily escape the stressful family relationships.

The substance use issues in his wife and son were brought up in conversation regarding the use of benzodiazepines in the patient's panic disorder. Mr. J expressed concern about the addictive potential. Nevertheless, he had utilized the alprazolam appropriately and as directed since the beginning of treatment, with great success, and after six weeks requested an appropriate taper of the medication. He proposed a plan to take the medication as needed for the following two-week period, and then he successfully discontinued its use without difficulty.

Mr. J's blood pressure normalized as the anxiety symptoms subsided. The primary care provider tapered and discontinued the amlodipine and later the metoprolol. The patient maintained normal blood pressure without pharmacotherapy and had achieved his goal of no scheduled medications. He continued his daily exercise routine and meditation. Appropriate termination was accomplished and the patient discontinued regular scheduled psychotherapy sessions.

Approximately two months following termination, Mr. J contacted the psychiatrist prior to leaving town for the first time since the onset of panic disorder. He had concerns that the symptoms of anxiety would return during his travel; he reviewed the various strategies and coping skills he had practiced during the early weeks of psychotherapy. The therapist reassured him that if it would be helpful to talk again by telephone at any point during the trip, he should not hesitate to call. No further calls were received, and Mr. J continues to remain stable and symptom free.

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DISCUSSION

Panic disorder is an anxiety disorder, and is associated with a number of physical symptoms. Anxiety disorders are the most common psychiatric disorders in the United States, and patients are seen frequently in a variety of settings. The direct and indirect costs of anxiety disorders are considerable, and the level of impairment can be severe. Mr. J suffered from recurrent, unexpected panic attacks following a motor vehicle accident, developed persistent concern about having additional attacks, worried about the implications of the attack or its consequences (e.g., losing control, having a heart attack, "going crazy"), and had a significant change in level of function because of the attacks. Because of the frequency and severity of the panic attacks, and the medical work-up that produced no organic cause for the symptoms, Mr. J met criteria for panic disorder.

Supportive psychotherapy informed by dynamic principles was useful for this patient. Some patients with refractory symptoms will require referral for cognitive behavioral psychotherapy that has been empirically demonstrated.[5] In this case, the patient's existing defenses and coping skills were strengthened and developed in order to provide symptom relief as quickly as possible, using a combination of supportive and cognitive-behavioral techniques.

Supportive psychotherapy is an eclectic form of psychotherapy that is useful and widely practiced in multiple settings and service delivery systems. The techniques used in supportive psychotherapy are evidence-based.[5] The goals of supportive psychotherapy include reducing behavioral dysfunction and subjective mental distress, as well as supporting existing adaptive coping skills while maximizing autonomy and independence. The working alliance formed in supportive psychotherapy provides the necessary forum in which these issues can be addressed and processed.

Panic attacks accompanied by phobic avoidance of driving were among the main sources of distress and dysfunction for this patient. During the first session, this patient himself was able to recognize that not driving was compounding his psychological and social problems. Although he had a friend drive him to the initial appointment, a typical coping strategy used by phobic patients, he decided that while this approach temporarily relieved his anxiety, it was not helping him to

improve and that he must resume driving. His decision to expose himself to anxiety provoking situations as well as reframing the need for this assistance of friends as "stupid" (his term) rather than "useful" was supported by the therapist. Frequently in such cases a therapist must counter the advice of well-meaning family, friends, and physicians who warn the patient to avoid anxiety-provoking situations.

KEY POINT: Using Some Cognitive-Behavioral Techniques in Supportive Psychotherapy

Many patients in supportive psychotherapy will benefit from cognitive behavioral approaches, but need more specific direction than did the high-functioning Mr. J. Mr. J spontaneously incorporated some of these cognitive behavioral strategies. He explored more specifically the cognitions that occurred during and after the accident and emergency department visit (when he experienced severe anxiety). Some patients will not do this on their own, i.e. because of dissociation, fear of re-experiencing the trauma, etc., and will need encouragement. As patients are encouraged to explore these cognitions, the therapist explains the signs and symptoms of panic attacks. This psychoeducation provides information to counter beliefs that these are symptoms of serious heart, respiratory, or neurologic disease, and helps the patient develop rational alternative thoughts to the worst case scenarios that are being imagined (that he will die, faint, lose control, etc.). Many individuals will require a stepwise approach to conquering their fears. This can be done by helping the person develop a hierarchy of fear, such as side streets, freeways, city interchanges, rush hours, and developing a gradual plan of exposure up this hierarchy.

Although Mr. J was able to vanquish his driving avoidance in a single session, he required a more incremental plan for returning to work until he was able to eventually return to a forty-hour schedule. He elected to not return to his prior habit of working sixty hours per week but this was a choice rather than a fear that his panic symptoms would return.

Another area in which cognitive techniques can enhance treatment for anxiety and depression is in altering the beliefs patients have about medication. This can improve adherence to treatment for those individuals who may benefit from combination therapy. Indeed Mr. J illustrates the ambivalent feeling and negative thoughts people have about not only psychotropic medication and their use of them but also the use of medication for general medical conditions, such as hypertension. Frequently patients express beliefs that they are weak, flawed, or failed people for not being able to manage depression or anxiety without medication. Such beliefs often lead to poor adherence with medication, resulting in ongoing struggles with depression and anxiety. Countering these ideas with questions about whether they would feel the same way about taking medication for diabetes or blood pressure or whether they would hold these ideas about a friend taking medication can sometimes help. However, as this case illustrates, the feeling and beliefs about medication may be more complex. Mr. J. coincidentally had been placed on the same medication used for his mother's condition right before she died. A patient may think that this is a start of an inevitable long decline in memory, energy, health, and independence as experienced by his mother. The therapist can reframe this idea to the thought that the medication is a tool which, if used early enough and effectively, may protect him from the same health problems his mother developed.

This patient also spontaneously engaged in behavioral strategies often helpful in managing depression and anxiety. These included yoga, treadmill exercises and meditation. A behavioral approach that can be incorporated into supportive psychotherapy could utilize other structured relaxation strategies such as progressive muscle relaxation, breathing retraining and self-hypnosis.[2,5] The goal of supportive psychotherapy is to provide alternative reaction to the physical symptoms of anxiety and alternative interpretations of the meaning of these symptoms.

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